National Summary of State Medicaid Managed Care Programs as of June 30, 1999

Glossary of CommonTerms

FFS	Fee-for-Service
FQHC	Federally Qualified Health Centers
RHC	Rural Health Clinics
PCP	Primary Care Provider

Section: Program Impact--Managed Care Arrangement Terms

PCCM

Primary Care Case Management Provider -- A PCCM provider is a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category includes any PCCMs and those PHPs which act as PCCMs.

PHP

Prepaid Health Plan is a prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis.

Comprehensive MCO

A ***Comprehensive MCO*** is a health maintenance organization, an eligible organization with a contract under '1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of '1902(w). These MCOs provides comprehensive services to both commercial and/or Medicare, as well as Medicaid enrollees.

Medicaid-only MCO

A ***Medicaid-only MCO*** is an MCO that provides comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.

HIO

Health Insuring Organization is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Section: Program Impact--Operating Authority Terms

1915(b)(1)	***Service Arrangement***. The State may restrict the provider from or through whom beneficiaries may obtain services.
1915(b)(2)	***Locality as Central Broker provision***. Under this provision, localities may assist beneficiaries in selecting a primary care provider.
1915(b)(3)	***Sharing of Cost Savings provision***. The State may share cost savings, in the form of additional services, with beneficiaries.
1915(b)(4)	***Restriction of Beneficiaries to Specified Providers provision***. Under this provision, States may require beneficiaries to obtain services only from specific providers.
1115(a)	***Research and Demonstration Clause***. The State utilizes specific authority within Section 1115(a) of the Social Security Act to allow the State to provide services through the vehicle of a Research and Demonstration Health Care Reform waiver program.
1902(a)(1)	***Statewideness***. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.
1902(a)(10)(B)	***Comparability of Services***. This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance.
1902(a)(23)	***Freedom of Choice***. This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.
1932(a)	***State Option to use Managed Care.*** This section of the Act permits States to enroll their Medicaid beneficiaries in managed care entities on a mandatory basis without section 1915(b) or 1115 waiver authority.

Section: Quality Activities Terms

Encounter Data — ***Encounter Data*** are detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as Ashadow claims@.

Utilization Summary Data — ***Utlilization Summary Data*** that are aggregated by the capitated by the capitated managed care entity (e.g. the number of primary care visits provided by the plan during the calendar year.)

Outcome Data — ***Outcome data*** are data that measure the health status of people enrolled in managed care resulting from specific medical and health inventions (e.g. the incidence of measles among plan enrollees during the calendar year).

Financial Data — ***Financial Data*** are data regarding the financial status of managed care entities (e.g. the medical loss ratio).

Grievances and Complaints — ***Grievances and Complaints*** is information about grievances and complaints submitted to the health plan.

Consumer Survey Data — ***Consumer Survey Data*** are data collected through a survey of those Medicaid beneficiaries who are enrolled in the program and have used the services. The survey may be conducted by the State of by the managed care entity (if the managed care entity reports the results to the State).

Provider Survey Data — ***Provider Survey Data*** are data collected through a survey or providers who participate in the program and have provided services to enrolled Medicaid beneficiaries.

Demographic Data — ***Demographic Data*** are data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include, but are not limited to, age, sex race/ethnicity, and primary language.

HEDIS Measures from Encounter Data

Health Plan Employer Data and Information Set (HEDIS) measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).

EQRO

EQRO Organization--Federal law and regulations require States to use an External Quality Review Organization (EQRO) to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.